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# One vs five sessions of exposure and five sessions of cognitive therapy in the treatment of claustrophobia

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## Abstract

Forty-six patients fulfilling the DSM-IV criteria for claustrophobia were assessed with behavioral, physiological, and self-report measures. They were randomly assigned to four conditions: (1) one-session (E1); or (2) five-sessions of exposure (E5); (3) five-sessions of cognitive therapy (C5); and (4) Wait-list for 5 weeks. The first condition consisted of a single 3 h session of massed exposure, and condition 2 and 3 of 5 h of gradual treatment, which was done individually by very experienced therapists. The results showed that treatment was significantly better than the wait-list condition, and the three treatments did equally well with no differences between them. At post-treatment 79% of treatment patients vs 18% of the wait-list controls had improved to a clinically significant extent. When the three treatments were compared 80% in the E1-group, 81% in the E5-group, and 79% in the C5-group were clinically improved. At the 1 year follow-up the corresponding figures were 100%, 81%, and 93%, respectively. The implications of these results are discussed. © 2001 Elsevier Science Ltd. All rights reserved.

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## 1. Introduction

Claustrophobia is one of the most prevalent specific phobias in the general population. Costello (1982) reported a prevalence study of 449 women in Calgary, Canada. Twelve percent reported having a fear of closed spaces, crowds or elevators, and 4% said that the fear was severe. Kirkpatrick (1984) investigated 342 women and 200 men in Indiana, USA. Of the women 22.5% said that they had a fear of enclosed spaces, and 13.4% reported the fear to be severe. Among the men 7.5% reported a fear, but only 3% said that it was severe. Chapman (1997) described the results of the large ECA-study in five US cities ( $N > 18,000$ ). The proportion of these fulfilling DSM-III phobia criteria was 2.4% for closed spaces, 2.1% for tunnels, bridges and 2.6% for

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crowds. There is no information as to the co-morbidity between these fears but the proportion having a phobia for any of these situations is probably 3–4%. Finally, in the National Co-morbidity Survey ( $N > 8000$ ; Curtis, Magee, Eaton, Wittchen & Kessler, 1998) the lifetime prevalence of phobia for closed spaces was 4.2%, which put it in third place after phobia for animals (5.7%) and heights (5.3%). In conclusion, except for the Kirkpatrick (1984) study there seems to be an agreement on the lifetime prevalence of claustrophobia at about 4%.

Despite this fairly high prevalence there are only two randomized treatment studies in the entire literature. Öst, Johansson and Jerremalm (1982) divided claustrophobic patients into behavioral and physiological reactors, respectively. Within each group the patients were randomized to three conditions; exposure in-vivo, applied relaxation, and a wait-list control. The treatment comprised eight 1 h sessions, once weekly. Results showed that among behavioral reactors exposure was significantly better than applied relaxation, while the opposite was true for the physiological reactors. Among those patients receiving the matched treatment 100% fulfilled criteria for clinical improvement, compared to 50% in the non-matched conditions, and 0% in the wait-list groups. The results were maintained at the 14 months follow-up assessment.

Booth and Rachman (1992) compared exposure in vivo, interoceptive exposure, cognitive therapy, and a wait-list control condition in a brief 3 h treatment across 3 weeks. On most measures the treatments were better than no treatment, while there were few differences between the active treatments. Exposure in vivo and cognitive therapy did better than interoceptive exposure on reported fear and exposure did better than the other two treatments on heart rate. However, the change in negative cognitions did not differ between the groups.

One possible explanation for this scarcity of treatment outcome studies on claustrophobia is that in the US at least claustrophobia is not usually considered a specific phobia but a prodromal stage to agoraphobia. Another reason may be that in most cases claustrophobia does not seem to be that handicapping and most sufferers have learnt to live with it, and thus they do not apply for treatment (Rachman, 1997). However, there is a fairly large proportion of claustrophobic patients who really are impaired by their phobia when it comes to work and social life, and this subgroup is the focus of the present study.

Research done during the last 10 years has shown that short intensive treatment during a single session maximized to 3 h produces just as good results as more spaced programs do for specific phobias. Öst, Hellström and Kåver (1992) found that one session of exposure was equal to five sessions in injection phobia, and Hellström, Fellenius and Öst (1996) showed that one session of applied tension or tension only were equal to five sessions of applied tension for blood-injury phobia. Öst, Brandberg and Alm (1997) found that the one-session treatment was equal to five sessions of gradual exposure in flying phobia. In spider phobia Öst, Salkovskis and Hellström (1991) found that the therapist-directed one-session exposure and modeling treatment was superior to patient-directed manualized treatment, and this was replicated by Hellström and Öst (1995). One-session group treatment of spider phobia has also been found effective in two studies (Öst, 1996; Öst, Ferebee & Furmark, 1997). Furthermore, Arntz and Lavy (1993), and Thorpe and Salkovskis (1997) have replicated the individual spider phobia treatment. Thus, from a clinical point of view the 1-session treatment can be considered the treatment of choice for specific phobias, at least for that subset of phobias for which it has been evaluated.

The first purpose of the present study was to investigate whether cognitive-behavioral therapy is better than no treatment for claustrophobia. The second aim was to test if the 1-session treatment

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